THE ALABAMA
MEDICAL JOURNAL.

VOL. 18. MARCH, 1906. NO. 4

Original Communications.

CASE OF GENERAL PERITONITIS.

By I. L. WATKINS, M.D.

MONTGOMERY, ALA.

February the 8th, I saw in consultation with Dr. J. L. Gaston, this interesting case, which gave the following history: Mrs. C., white age 28, married three years, two children, the youngest five weeks old. No trouble with either confinement, and had always been healthy. The day of consultation was Thursday. On Monday, Jan. 28th, she felt well in the morning, and rode about town a good deal. During the day spent some time fitting dresses and shopping. When she returned in the afternoon, she noticed a slight pain in her left side. It was not severe, and she did not speak of it. Being very hungry, she ate a hearty meal. Soon after this, the pain grew worse, and she telephoned the doctor for advice. She was advised to take some simple remedy for indigestion. The pain continued to grow worse until 12 m., when the doctor was called to see her. Diagnosis of acute indigestion was made. The principal pain was located in the left side, with cramps over the entire abdomen. Hypodermic of morphine was given, which did not give complete relief. The follow-

ing morning she was still very sore. Was ordered dose of castor oil. In the afternoon temperature was 104 and the abdomen distended, with considerable nausea and vomiting—which was attributed to the morphine. The bowels had moved well. At night papine was given, from which she had a very comfortable night. On the following morning I saw her. Her entire abdomen was somewhat sore, the principal pain located in the left side, temperature 101.5, pulse 90, vaginal examination revealed nothing. I concurred in the diagnosis, namely, that she was suffering from general toxemia. All nourishment and medicines by the mouth were stopped, and colonic flushing ordered every three hours, with hot fomentations to the abdomen. This was followed by free evacuation of the bowels, and relief from pain, but the distention continued. She continued comfortable for two days, and I saw her at ten o'clock Saturday night. Her bowels had not moved for 15 hours—abdomen greatly distended, pain in the epigastrium and distressed breathing, temperature 101.5, pulse 110. A nurse was asked for to superintend the giving of enemas to which ox gall was added. Saw her again next day at noon and was informed that nothing had been accomplished by the enemas. Temperature 102, pulse 120, expression bad, and very restless. The condition was clearly a bad one, and evidently one of peritonitis. An operation was advised and promptly agreed to. It was thought unwise to move her to the hospital, and as quickly as arrangements could be made it was done at the house, assisted by Drs. Blue, Gaston and Billing. She came near dying in primary anesthesia, and to proceed further was regarded doubtful propriety. The abdomen was opened, and large quantities of pus poured from the peritoneal cavity. A hurried exploration was made of all the organs, and nothing found to account for the condition present, except the left falopian tube was perfectly black for two-thirds of its length from the fembriated extremity. There were no adhesions nor bands, nor other evidences of disease. The tube was not enlarged, and there was no evidence of intestinal leakage. There was more than a pint of pus in lower cavity, and the intestines here showed a more advanced stage of in-

flamation. As the condition of the patient was hopeless, we inserted a liberal quantity of gauze in the cavity and placed her back in bed. She lived only three hours.

The starting point of infection in this case was, undoubtedly in the left iliac fossa, but the condition which brought it about, is not easy to determine. The falopian tube was not adhered to, nor constricted by any other tissue, but was lying perfectly loose in the cavity. Why was it gangrenous? Certainly its nutrition had been interfered with in some way. One of the routes by which infection may reach the peritoneum is, from the vagina or uterus, through the falopian tubes and it is very probable that the infection here took this course, but this is no reason why the tube should have been gangrenous. It is to be regretted that we did not have the time to search more carefully for the explanation.

CERTAIN FEE TABLE ITEMS THAT INJURE THE GENERAL PRACTITIONER.

By D. W. Cathell, M.D.

BALTIMORE, MD.

Sixty or seventy years ago, when the sciences on which modern medicine is based, chemistry, physiology, pathology, bacteriology, physiological chemistry, etc., had practically no existence, and medicine was practiced on a much more uncertain and a much less satisfactory basis than now, and the medical profession was composed almost entirely of General Practitioners, all doing the same kind of work, and all facing very tangled and unsatisfactory financial problems; in their endeavors to better this bad condition, Fee Tables were devised and adopted by the practitioners of different sections, and these relics of those days are still in existence, and looking at them to-day we find the custom of estimating the amount due the General Practitioner from this or that patient is still reckoned by the number of times the physician visits a patient, or the number of times he consults the physician at his office, with but little or no regard for

the nature of the case attended, or the degree of skill required.

But within these sixty or seventy years everything medical has undergone a change, and although such a plan may have been the wisest for our profession then, it is certainly not so now, because we of to-day live in an era of increased medical, and surgical, and hygienic knowledge, and consequently of much greater average professional attainment among medical men generally, and this marvelous growth of medical and surgical wisdom and skill has caused to spring up in all our large cities and towns a great number of well-qualified medical men who devote themselves entirely to various Special Branches of Study and Practice, and in consequence of their advent, our profession now consists of two great divisions: The Specialists: surgeons, gynaecologists, larynologists, oculists, neurologists, alienists, orthopedists, proctologists, etc., in one division; and in the other, not confined to any one location, but scattered here, there and everywhere throughout the land, another and more numerous body known as General Practitioners.

In former days, these professional fee tables were supposed to govern every member of our guild, but now, owing to the very satisfactory work being done by our specialists, and their consequent excellent reputation as a body, the size of their charges for services is no longer controlled by these Rip Van Winkle fee tables, for which they have but little or no respect; but in lieu thereof, each man among them establishes for himself some more or less definite financial policy of his own, and each puts his own value on his services, and each usually takes care to charge each patient a sum large enough to materially aid in giving him and his dependents a comfortable support, with some addition for their needs when he is no longer able to work: and each rightly leaves his medical neighbors of every kind to shape their own financial policy, so that to-day this old fee-table method of computing fees by the visit governs none of our numbers except the general practitioners, and as far as the best interests of these are concerned, they govern them in the wrong direction.

Of course, in our noble and humane profession everybody, whether specialist or general practitioner, willingly and justly does, and I hope always will do, his share of "no charge" work among the worthy poor, and each also has cases in which he willingly gives those who deserve it, "a poor man's bill," and also for one reason or another, often gets but little or nothing, sometimes not even "Thanks," for very valuable services, occasionally for saving life itself; and every specialist and every general practitioner alike also encounters transient, indefinite, chronic or minor cases in which he charges only a meagre pay-by-the-visit fee, whether by the house-visit or for services at his office.

But when it comes to important and well-marked cases, in those able to pay full prices there exists a very wide and very deep chasm between the custom of the two professional bodies, for the specialist then justly ignores all details and charges a bulk sum for his services, while his brother, the general practitioner, in calculating the amount of his fees for cases often equally or more important, many times involving life itself, unjustly limits himself to counting the number of visits made with but little or no regard to anything else.

Look at any of these fee tables with this in mind and you will see that almost every item of the work done by the surgeon, or other specialist, speaks of a specific and just sum, and that, on the contrary, every item of personal interest to the general practitioner ignores the true base for charging, almost as though some hostile manipulator had purposely established the custom as a handicap, compelling him always and everywhere to found his charges, not on his skilful efforts, but on ignoble and incidental grounds; and to-day, in practice, while the fees of all others are measured by their skill and services, the G. P.'s skill and services, no matter how valuable and successful, are totally ignored, and his claims are measured by the unjust and belittling standard of "How often he pulls his patients' door-bells, or how often they pull his," and consequently it is seldom, very seldom indeed, that he receives a full and just fee; all because he is handicapped by this ancient fee-table custom, which meanly

measures his services by bell knobs, mile posts, etc., instead of by the worth of important services rendered by a skilful medical man.

All who have studied the subject know that ignoring or abolishing these fee-table wrongs, would neither bring the medical millenium, nor be a panacea for all the general practitioner's hardships, nor cover every distasteful and unjust feature of his practice, but it would give him fee-table authority to charge for pneumonia, typhoid fever, diphtheria and everything else, by the case, whenever it is proper and possible to do so, and would, in many cases, enable him to lift his claims from a mean and belittling standard to a far nobler one for himself, and a much better one for his pocketbook.

When the surgeon of to-day, or a gynaecologist, or an oculist, or a proctologist, or a specialist of any kind, renders services to a patient, his better business system enables him to "lump" his fee into a round sum of even figures: five, ten, fifteen, twenty, twenty-five, fifty, seventy-five, or a hundred dollars, and so on, up, and as everybody knows, instead of its injuring him, his round charge actually enhances his prestige in the estimation of all who hear of it, and he is apt to receive his round and satisfactory fee promptly, with but little or no haggling and with but little or no rebate.

But when Dr. Small, a general practitioner, after a long wait, finally dares to render Mr. John Doe his huge bill for the ragged amount of twenty-nine dollars for services extending over many months, the astonished Mr. Doe, with our ball and chain fee-table way of counting in his head, wonders how in the name of Julius Caesar he owes the doctor so much, and Doctor Small is apt to be asked how often, and for whom, Mr. Doe's door-bell has been pulled by him since he was paid; and when Mr. Doe's items are furnished they will probably read about as follows: Son George and Ida, Scarlatina, 9 visits; Henry, Tonsilitis, 1 visit; Milton, Tapeworm, 3 visits; Grandfather, Cyctitis, 5 visits. Viola, Headache, 1 visit; baby Ruth, Broncho-pneumonia, 6 visits; Obediah, passing renal Calculus, 4 visits; total, 29 visits, and even then poor Doctor Small, seeing that there still exists some dissatisfaction, as a matter of policy or from

pinching need of money, may actually receipt the bill for twenty or twenty-five dollars. But, it is not this belittling financial injustice that goes most to Doctor Small's soul, but it is the discovery that all his skill and all his kindness to the Doe family are so soon forgotten, and that the old 1840 fee-table way of paying the general practitioner so long and accurately remembered.

Must our brotherhood in America continue to follow this old plan forever? No, no, in the name of Justice no! Our whole population is, everywhere, living under very different financial conditions from those of that old by-gone period, and to-day it is the duty of every medical man to his profession, to himself, and to his pocket-book, to base his charges on professional ability and on the character of the demands made on it by this or that patient, as often as it is possible to do so, instead of on a chalk-mark count of the number of visits; and, in my judgment, every item on fee tables not pertaining to specified items of professional services rendered, should be formally expunged; because now they are harmful to the financial interest of the very ones our medical forefathers designed them to protect; and whether our official authorities do this in meeting assembled, or not, every medical man in America who has not already done so should begin and studiously ignore them whenever and wherever it is possible to do so, and in lieu thereof make skill and services the foundation of all his charges; taking care that the amount named in each and every case be sufficiently large and round to silently cover visits, detentions, distances, and all other incidentals; because, by so doing, he will surely enhance his own reputation for skill, and at the same time, get better returns for his work; and also be aiding to instil into the public mind a more lofty and a more just standard by which to compute the worth of the services of the general practitioner, for then, and not until then, will this worthy division of our profession have the benefit of the better system it now so badly needs.—Medical Times.

MEDICAL AND SURGICAL EMERGENCIES—WAYS TO MEET THEM.

By A. H. SIMONTON, M.D.

DELIGHT, PIKE COUNTY, ARK.

Late Surgeon U. S. Army, Spanish War.—Went from Birmingham, Ala.

One of the difficult problems the country practitioner has to meet is how to handle emergency cases, both medical and surgical. In the absence of desired appliances, the doctor frequently has to do some hard thinking, and then act quickly. Such calls may come when he is miles away from his office, no time to return for anything wanted, so must be attended to at once, using whatever is obtainable in the emergency. I will mention various appliances that may be utilized for many things, which I have in part selected from various sources; and several others, most of which I have used.

A scroll-saw, with an assortment of a dozen saws, can be purchased at the hardware store for twenty-five cents; it is ideal for resection of the small bones of the hand and foot, for amputation of the digits, etc. Well tempered carpenter's chisels and gouges, and a carpenter's mallet answer the purpose admirably for bone work. A useful bone drill can also be selected from the stock of the hardware dealer. A gardner's pruning knife and a carpenter's miter saw are the best tools for the removal of plaster dressings. A cheap potato knife, rough sharpened on a stone, is excellent for cutting through starch bandages. Crotchet needles are most useful for lifting buried stitches out of a sinus.

Knitting needles find another purpose as a means of rupturing the membrane when this is needed, as it often is, in obstetrical work. Sharp and blunt retractors may be fashioned in an emergency, by bending the tines of a fork and the handle of a spoon respectively. A teaspoon is also useful as an elevator of the eye, when resection of the superior maxillary is performed. An inverted tea-strainer is useful in the dressing after colostomy, to prevent pressure of the gauze upon the gut. A spoon shaped potato cutter may be used, in an emergency, as a wound curette. Similarly, applicators, probes and depressors may

be improvised by twisting stout copper wire. The multiple surgical uses of the hairpin are also well known. Of stouter material, if necessary, a small self-retaining speculum can be quickly made from steel wire; it often obviates the need of an assistant when searching the hand or foot for a foreign body.

An excellent splint for leg or arm can be quickly made of bunch grass or willow twigs if nothing better is available.

Cigar box or card board makes a good splint for fingers or toes. I have used a postal card for this purpose, happening to have one in my pocket. Even a folded newspaper is, at times just the thing.

A plain top lamp chimney, for toy or night lamp, makes a useful speculum.

The most difficult emergency case I ever had with nothing to do with, was in 1876 when on my way to the Black Hills. We had a "scrap" with the Indians. Four of us being cut off from the rest of our party by the Indians. One received a wound in the right side, breaking the seventh rib, forcing it inwards, severing the intercostal artery, causing internal hemorrhage. It was necessary to stop that hemorrhage, but how could it be done? We were safe from attack for the time being, but could not get back to the wagons and our friends could not get to us. I found, on investigation, that my available appliances consisted of one clean white pocket handkerchief, a hunting knife and our firearms. I had to do some hard thinking, which resulted in my forcing the center of the handkerchief into the wound, then pushing buffalo grass in to form a wad, then using the knife as a lever to pull the rib into place and apply pressure to the severed artery, thereby stopping the hemorrhage and saving my patient.

If you carry screw top bottles in your case and will use liquids, especially iodine, put corn stalk pith in your screw cap, instead of shaved cork, and it will stop the leak.

Your case will not be complete without a good and ever present supply of calcidin tablets called "Tonsilitis," also intestinal antiseptics and saline laxative, all made by the Abbott Alkaloidal Company, Chicago. With the calcidin you can certainly cure practically every

case of croup, if called in time and if you push the remedy. When called to a case of croup, I always give the messenger a little envelope of calcidin tablets with directions written on it, and hurry him back and then take my time to dress and follow after. It is not unusual to find the little sufferer much relieved on my arrival. My own boy, four and one-half years old, was taken with his first case of croup about midnight, and had I not acted quickly, could not have lasted five minutes. I sprang from bed and administered calcidin at once and pushed the remedy. In half an hour the danger was past and the child asleep. The following day he coughed up a tough membrane. Calcidin saved my boy, do you wonder that I praise it? I get as good results from the use of the Abbott Alkaloidal Company's tonsilitis tablets for tonsilitis, acute pharyngitis, ulceration of tonsils and glandular affection of throat and neck. I combine calcidin with this tablet and believe I get quicker results by so doing. Their "Intestinal Antiseptic" is another indispensable remedy. If you will use this remedy as directed on three cases, you would not drop it out of your list of necessary remedies for money.

PNEUMONIA.

By A. H. Simonton, M.D.

DELIGHT, ARK.

Pneumonia seems still to be considered a "self-limited disease," and to be treated on the "Expectant" plan, watching for the crisis and hoping that the patient has sufficient strength to help him to "pull through."

In my opinion, the "Expectant" plan the physician should adopt is to expect to cure the patient, and if called early in the case, to abort it. This course indicates thought, prompt and efficient action. Most doctors dislike anything that requires any special effort on their part, preferring routine doling out of remedies, giving hurried and stereotyped directions, promising to call again in twenty-four hours,

and going away feeling relieved that the call for the day is over.

That does not meet the situation or relieve the physician of responsibility. In the South, we seldom have a trained nurse, depending entirely upon the family or upon neighbors to nurse the patient, who sit up in pairs for half the night, and change with another pair of watchers for the remainder of the night. This method of nursing, though prompted by the kindest motives, make the doctor's responsibility far greater and requires more careful attention to details. He must not only prescribe a jacket of cotton for the patient, it being obtainable everywhere in the South, but he must superintend the making and the fitting of it, and see that it is put on at once.

He must clean out the prima via with 1-6 grain doses of calomel and podophyllin, half hourly till one-half to one grain of each has been taken, then follow with Saline Laxative, one heaping teaspoonful in hot water every hour till the bowels move freely, then give "Intestinal Antiseptic (W-A)" every two hours, or enough to keep the bowels sweet and clean.

In full blooded patients, begin with aconitine, veratrine and digitalin, one granule every fifteen to thirty minutes until pulse softens, then every one-half to one hour. If patient is weak, give strychnine arsenate in place of veratrine. Codeine is excellent to quiet the cough, and emetine for expectoration, and cactin for prompt relief of heart waverings.

Secure quiet and rest no matter how much medicine is required to do it. To conserve the strength of the patient and build up the tissues from the start, give nuclein solution in twenty drop doses three times a day, taken on the tongue without water.

The gist of the whole thing being, "local protection, elimination, forced defervescence, intestinal disinfection, systemic disinfections, and strong support to nature's fighting forces." When I have been called early to a case of pneumonia, I have, for fully ten years, succeeded in aborting it by the above treatment, or reducing its severity and saving my patient.

My main difficulty has been the nursing, and I paid special atten-

tion to that and found the volunteer nurses willing and attentive, and when instructed, usually efficient.

LEUCOCYTOSIS IN APPENDIX CASES.

By Ira J. Sellers, M.D.

BIRMINGHAM, ALA.

During the past few years, and I might say at the present time, there is not anything more popular with the profession as a whole than to be guided largely by the leucocyte count in appendix cases. Some go so far as to almost, if not entirely, disregard the clinical symptoms and depend on the leucocyte count for either good or bad according to the excess above the normal. If the count is near normal the idea is not to operate and in some instances to even doubt the correctness of the diagnosis of appendicitis.

This idea no doubt has been greatly stimulated by statements made not many years ago that "the leucocyte count would mark the line between inflammatory and non-inflammatory conditions." This no doubt is true in some instances, but certainly it will not hold good in all, and for this reason it will not do to be guided by and we must rely on the clinical symptoms.

I doubt if there is any one who has observed a dozen cases where the leucocyte count was depended on, who has not seen disastrous results. It sometimes happens that when repeated counts can be made a gradual increase will be observed. This may increase out of all proportion to the clinical symptoms.

In some instances a high or a low count will correspond with a mild or a severe case. Take an acute catarrhal attack with pain, tenderness and vomiting, pulse 80 to 100, temperature 100 to 101 F, the count may be found anywhere between 6,000 and 40,000. In most cases however between 12,000 and 20,000. In some cases adhesions form rapidly and in a few hours the count will be found much lower. As the area of inflammation is walled off with adhesions the leucocyte count

falls and many times the clinical symptoms improve for the time being and operation is delayed. In other cases of the severest type the same blood conditions are observed. If the leucocyte count was not depended on at all probably the case would come to the operating table promptly (where every case should come).

As a matter of knowledge it is a nice thing to know what the count is in a given case and when possible I make it regardless of whether I am going to operate or not. I would not in any case let a low count defer operation, for a rule it is a bad thing for the patient and many times for the operator. I think it can safely be said in a broad sense that the leucocyte count is of no clinical value. It is an instance of another passing "fad." It does not give a true idea of the pathology, and if the clinical diagnosis can be made no time should be lost with a leucocyte count. It does not tell us when to or when not to operate.

It is a matter of common knowledge that the only safe thing to do is to remove all inflamed appendices. I have tabulated thirty-five cases with reference to leucocytosis, having excluded all counts in which I did not operate, also those where the blood was taken during or immediately after operation, leaving only those in which the count was made shortly before operation. In two-thirds of my cases no count could be made.

Under the head of "Remarks" I have noted the findings which interested me most. The table follows:

No. 1. Female, white cells 22,500.—Forty-eight hours duration. Gangrenous appendix.

No. 2. Female, white cells 14,000—Thirty-six hours duration. Small abscess well walled off. Ruptured appendix. Repeated attacks.

No. 3. Male, white cells 16,000—One day's duration. Appendix filled with pus. Large amount turbid fluid.

No. 4. Male, white cells 13,700—Three days duration. Offensive fluid. No adhesions. Appendix filled with pus.

No. 5. Male, white cells 7,350—Two days duration. Ruptured appendix. Large area peritonitis. Temperature 103 F.

No. 6. Male, white cells 32,400—Ten days duration. Large abscess. Age three years. Temperature 101 1-2 F.

No. 7. Female, white cells 8,100—One day's duration. Acute catarrhal. Appendix filled with pus.

No. 8. Male, white cells 14,000—Twelve hours duration. Second attack—white cells 9,450—Eighteen hours duration. White cells 20,350 Twenty-four hours duration. Operation. Gangrenous appendix. Few adhesions from former attacks.

No. 9. Male, white cells 9,550—One day's duration. Gangrenous appendix. Third attack. Much depression.

No. 10. Male, white cells 15,150—One day's duration. Acute catarrhal.

No. 11. Male, white cells 22,700—Two days duration. Acute catarrhal. Temperature 102.

No. 12. Male, white cells 6,750—Three days duration. Small abscess well walled off. Much depression.

No. 13. Male, white cells 7,900—Four days duration. Second attack. Small amount of pus well walled off. Very tender.

No. 14. Male, white cells 23,200—Seven days duration. Large abscess well walled off. Very large concretion.

No. 15. Female, white cells 26,100—Ten days duration. Very large abscess.

No. 16. Male, white cells 14,300—Two days duration. Several attacks during past three months. Many adhesions. Small amount of pus.

No. 17. Male, white cells 21,500—five days duration. Ruptured appendix. No adhesions. Septic peritonitis.

No. 18. Female, white cells 8,500—Chronic catarrhal.

No. 19. Female, white cells 9,100—Attacks every three or four week for several months. Many adhesions.

No. 20. Female, white cells 11,500—Two days duration. Acute catarrhal.

No. 21. Male, white cells 7,200—Seven days duration. Chronic.

Very painful.

No. 22. Female, white cells 14,200—Third day (recurrent attacks). White cells 12,405—Fourth day. White cells 16,200—Fifth day. Constant pain. Operation. Appendix filled with pus.

No. 23. Male, white cells 38,800—Four days duration. Small amount pus. Fairly well walled off.

No. 24. Male, white cells 29,550—Eight days duration. Large abscess. Temperature 102 F.

No. 25. Male, white cells 12,200—Six days duration. Abscess.

No. 26. Female, white cells 7,250—Two days duration. Excruciating pain. Appendix filled with pus.

No. 27. Male, 20,800—One day's duration. Turbid fluid. No adhesions. Exceedingly tender.

No. 28. Female, white cells 10,600—Two days duration. Turbid fluid. Pus in appendix.

No. 29. Male, white cells 11,750—Five days duration. Abscess well walled off.

No. 30. Male, white cells 8,300—Eighteen hours. Great pain and vomiting. Temperature 101. White cells 14,600. Thirty-six hours. Still painful. White cells 32,900. Forty-eight hours. Very painful. Temperature 102 1-2 F. Operation. Small amount of pus. Much turbid fluid. Very few adhesions.

No. 31. Female, white cells 36,100—Three days duration. Former attacks. Temperature 103 F. Age five years.

No. 32. Male, white cells 6,600—Chronic catarrhal. Appendix much enlarged. Many firm adhesions.

No. 33. Male, white cells 42,200—Eight days duration. Large abscess. Temperature 102 F.

No. 34. Male, white cells 19,700—Thirty-six hours. Former attacks. Small amount of pus. Many firm adhesions.

No. 35. Female, white cells 7,300—Four days duration. Small amount of pus.

From the above table it will be seen how irregular the leucocyte

count runs. By comparing the counts with the operative findings it will readily be seen that they do not give us anything like a correct idea of the pathology as was at one time thought. I doubt if there is any one who operates regularly who has not been asked the question: "What about the leucocyte?" It is so and so and this would not indicate any haste for operation. Could we not wait until tomorrow, or until the leucocyte count would call for operation? In some cases it is true that nature takes care of the trouble for the time being, but in many cases we all know what the disastrous results are when procrastination is the watch-word.

If the few cases in the above table be looked over it will be seen that the leucocyte count can not be depended upon. Cases 9, 12 and 13 may be taken as examples.

Hubbard, in reviewing the counts made in the surgical wards of the Massachuestts general hospital concludes that: "While the leucocyte count may be of value in helping us to distinguish between appendicitis and non-supurative affections, it is of little value when the diagnosis of appendicitis has been made in helping us to predict the course of the case, or in guiding our judgment regarding the time to operate."

A study of this statement shows that he questions its value in every respect.

Bloodgood, summarizes: "Acute cases early 8,000 to 22,000. Acute cases at end of attacked 8,000 to 15,000. Chronic cases subnormal with few exceptions."

It will be noted that he gives a wide range in which the count may be found, and this alone would preclude the possibility of saying from the count what the pathology might be (whether mild or severe), and we would be in no better position with reference to the patient than before.

Cases 8, 22 and 30 shows a steady increase in the leucocyte count.

It has been said that in a general way this is a bad indication. This may be true in some instances, but it will not hold good. Several times I have found an increase for twenty-four hours with a steady

improvement in the clinical symptoms and a speedy recovery without operation.

Cabot says: "A low count (8,000 to 11,000) means one of three things; a mild case, a very severe case, an abscess walled off." It is clear from this statement that we must decide at the bedside from the clinical symptoms what course is best to pursue. Cabot's statement leaves us where we started and is within itself sufficient to settle the question. "Mild, severe or pus walled off," would be poor consolation to any patient. I have had a number of cases referred to me for operation where a low count or mild clinical symptoms or both caused delay and they have invariably been pus cases. This not only means that it will take a much longer time for the patient to recover, but in addition, that at best, there will of necessity be a small hernia, which will call for the long continued use of an abdominal supporter and may become a serious matter with the laboring classes.

Cases 5, 9, 12 and 13 are good examples of Cabot's statement. In such cases the leucocyte count is of no practical value and if depended on for guidance the results from procrastination would necessarily be disastrous. We can not be sure in the majority of cases just what the pathology is until the abdomen is opened. Now, of what practical benefit can a leucocyte count be to either patient or doctor?

As stated above it is a very nice thing to know what the count is in a given case, but when we know it does not help us in a practical way, why should we lose time with a count?

REMARKS ON HEADACHE.

By W. Groce Harrison, M.D.

BIRMINGHAM, ALA.

In the selection of this trite subject and in the preparation of this rambling paper, the writer has had no theory to explode and no dogma to expound.

He will advance no new ideas—but hopes to arouse a few dormant ones—often useful, but not sufficiently utilized.

The sole purpose is to precipitate full wholesome discussion and to stress the importance of thorough search for the underlying causes rather than appease our conscience and dope our patients by promiscuous prescribing.

A retrospective view of medical progress shows a slow but steady tendency to etiologic classification. Dropsy is no longer a disease—but merely a sign-board and suggests the direction of further search. Pernicious vomiting of early infancy was long regarded as a distinct entity, but the past two decades have proven it a single symptom of pyloric stenosis.

And so, in the younger days of medicine, infantile spasms, mouth breathing, eneuresis, anaemia, vertigo, headache and various other symptoms were accepted as real diseases. We now must accept them only as signs—symptoms—nature's method of registering complaint.

Headache is the most frequent symptom we meet. It is often present in many chronic conditions and sometimes present in most acute disorders. Like the poor it is always with us. Indeed its frequency has made us often careless of its import as a symptom and forgetful of the suffering it entails.

Referring to the etiology of headache Butler gives eight different classes of causes. Sajous' Annual details seventy-seven separate and important reasons for the existence of this symptom. Wharton Sinkler writing in Hare's System of Therapeutics mentions some sixty or more causal factors, and so with various authors—all of which goes to prove it is an exceedingly frequent and often perplexing condition.

The remedies advised are no less numerous. The Twentieth Century mentions nearly a hundred various drugs and measures employed to palliate this symptom or remove its cause.

The training and mental attitude of specialists tend to enlarge and to exaggerate the importance of their line as causal factors.

Tis natural for every man to magnify his own calling, to extol the virtues and belittle the vices of his own profession. As a result we have the amusing spectacle of every specialist regarding head-

ache as the most probable result of some special cause with which he is particularly conversant.

Commenting on the foibles of the old Roman rulers, Gibbons aptly says: "Every physician is prone to exaggerate the inveterate nature of the disease which he has cured."

Deny it as we may, tis often true and this fact may partially explain the innumerable drugs, lotions, smelling salts, etc., popularly praised as infallible cures.

Let a patient with headache consult a nerve specialist and the latter thinks instinctively of over work, brain fag, neurasthenia. The same party may consult a gynecologist and his excellence, especially if the pain be in the vertex, sees visions of a torn cervix or congested ovary.

I've heard of one Gynapod who expressed surprise that men should ever have headaches at all—since they possessed no ovaries and had no uterus.

The eye man believes headaches practically synonymous with refractive errors and is prone to undervalue the weight of other factors.

If this pain tortured victim stumbles into the office of our classical Genito Urinary brother, the latter hastily recalls all his known causes of headaches and can think of none save secondary syphilis. To him the cause and the remedy are embraced in his favorite epigram "Two hours in the embrace of Venus—two years in the clutches of Mercury."

Dr. Haig and his enthused followers find in uric acid the one sine qua non and so the list might be continued. From the patient's point of view this is discouraging.

When he has been permanently relieved by half a dozen of these eminent specialists he too often finds himself still "in the gall of bitterness and the bonds of iniquity"—and proceeds to answer Pope's query, "Who shall decide when the doctors disagree"—by resorting to some of the unfailing cure alls so extensively advertised. Under such conditions a person is prone to share the sentiments expressed by young

Walter Raleigh to Queen Elizabeth, "Ah! we know what larum belongs to the discord of doctors."

We should regard the pain merely as a signal—sometimes a flickering faint light, but it has a meaning and it is ours to search out the hidden cause and remove it. Sometimes the task is easy, the road is blazed and the path well worn, but more often will it require patient study of the history, habits, duties, temperament and finally general examination of the party.

Since the intelligent and successful therapy depends in large measure on our ability to discover and remove the cause it behooves us to bear in mind some of the most frequent causes and to institute a thorough routine and systematic examination of the patient and endeavor to locate the trouble or at least to narrow it down to two, three or possibly four probable causes. With this scheme in mind I'll discuss hurriedly, but in detail, some, only a few, of the more frequent causal fastors. I omit headaches due to fevers, infections, drinks.

(1) Decayed teeth. Dental text-books are almost silent on this subject, but the cases are frequent. As a rule 'tis a molar at fault and may be in either jaw. Ear men are all familiar with the severe otitic pain frequently resulting from defective teeth and the latter cause temporal and parietal headache. It is of a neuralgic nature and is often aggravated by striking on the shell or root of the decayed tooth. The latter is sufficient to demonstrate its causal relationship.

Hare says 40 per cent of all and 80 per cent of all frontal headaches are of ocular origin. Certain it is, many of the most persistent and annoying instances belong to this cause. They are of several classes—that is, due to strain of several different eye muscles, and such class often presents its peculiar features.

There are few perfect eyes. Focal errors necessitating abnormal ciliary activity are present in 80 per cent of our school population, but this abnormal activity doesn't always produce symptoms, and unless it does it is a mistake to prescribe lenses. A child with an eye

requiring excessive ciliary contraction to focus parallel rays may and does often have a headache due to other causes.

The headache from the ciliary muscle may be in any part of the head, though more frequently frontal. Such patients often show redness of lids and congestion of the conjunctiva. The pain disappears at night and is uniformly aggravated by near use of the eyes.

Another frequent and often most perplexing form of ocular headache is that due to imbalance of the external eye muscles. The External Rectus may be too strong for the Internus, or vice versa. Muscles must so direct position of each eye that the image looked at will form its picture at the macula. In this way we get our sense of perspective. One muscle is often too strong for its antagonist, requiring the latter to be in a constant state of undue tension. This produces severe headache, and it is often attended with vertigo, nausea and a sense of drawing in the eye. It attends all near work and is likewise aggravated by railway travel and attendance on theatres. It is seen in its worst form after witnessing a moving picture exhibition. The effort of the weaker muscles to maintain single vision under these trying circumstances is a most prolific source of headaches.

A third frequent and annoying form of ocular headache is that produced by severe strain on the circular fibres of the iris to exclude excessive glare. The light may be too intense, the circular fibres may be unduly weak, or the retina may be too sensitive. In either case the result is the same. The circular fibres are strained unduly because fatigued, and quick, severe headache warns us to provide rest. This form of headache is usual on the sandy sea shore, and at Chicago became so frequent as to dubbed "the Exposition headache."

Many strong, vigorous patients have focal errors and muscular imbalance but show no symptoms. The physically weak and nervously unstable will be sufferers from eye strain more often.

Dr. Savage aptly says: "The nervous centers of the one may be compared with the steady leaves of the oak which are shaken only by

a wind, while the nervous centres of the other may be compared to the leaves of the aspen tree, which quiver in the slightest zephyr."

(3) A third and prolific cause of headache is mouth treating. This is especially frequent in children and is stressed by Roth, Osler and other recent authors.

The stuffiness of acute rhinitis is due to engorgements of the turbinate resulting in defective ventilation of the frontal, ethmoid and sphenoid sinuses, but the headache from mouth breathing is different. It is often from adenoid vegetations, enlarged tonsils, enlarged turbinates, spurs, et cetera. Dr. Osler has laid special stress on this condition, and even the enthusiastic nose men have not yet recognized the fullest extent of this evil. Worse in early morning, but comes any time—disappears and reappears often.

(4) Sinus disease is a more rare cause of pain and yet the few cases suffer most intensely.

This is generally present on waking, and is especially severe for two or more hours. If after the patient moves about, blows his nose and cleans the discharge out, the sinuses can drain, it may disappear, but if this can't be done then the party may continue to suffer till nature or art opens a way. In this class are most of the so-called sun-pains of earlier days. The pain in frontal sinus disease is over the cavity, in ethmoid it is between eyes and back of head, in sphenoid it is in vertex or occipital region, and in antral disease may be any where. They are uniformly aggravated by lowering the head and often temporarily palliated by local applications of cocaine and adrenaline. Of course thorough drainage and proper antiseptic surgical measures offer permanent relief.

Gynecological in Origin.—In his excellent work on refraction, Thorigton justly says: "The Gynecologist has pre-empted vertical headache," and it is true that the reflex head pain from the generative organs seems to be more often in the vertex. A glance at the unique diagrams of Brunton or amorous photographs of Butler would seem to make differential diagnosis depend solely on the location of

the pain. Four years ago I reported a series of peculiar reflex headaches found in gynecological cases. In one case I gave lenses, treated for uric and only after three months and repeated failure did I even suggest a vaginal examination. The cervix was badly torn and but a touch on the scar tissue in angle of tear produced excruciating paroxysms.

Local measures, cautery, etc., afforded no relief but prompt recovery followed cutting out the cicatrix and closing the tear. I am persuaded there must be many such cases. I know not how to detect nor even to strongly suspect their existence without a proper local examination. Many there are, doubtless also reflex from ovarian disease. The presence of other attendant symptoms say leucorrhoea, dysmenorrhoea, local tenderness, heaviness would urge the necessity of a thorough investigation.

(6) Cardiac valvular lesions, especially aortic narrowing, are frequent causes of an abiding, heavy, overful sensation and if accompanied by vertigo (as is frequent) it may completely unman our patient.

The usual coal tars may kill him quick but can't even palliate his condition. Alimentary regulation, enforced rest and bromids would likely afford a measure of relief.

(7) Arterio-Sclerosis—that sly sign of approaching age is quiet in its manifestations. The older text-books barely mention it. In his last edition Osler stresses its importance. These cases require special study. Rest, change of habit are not less essential than nitro glycerine and prolonged Iodide Therapy. They are easy to recognize if we are looking for them.

(8) The over burdened or impaired digestive apparatus furnishes its quota of all reflex disturbances. As all man's organs are taxed to provide grits for this voracious mill—so broken down, it reaps revenge on hands, heart and head. Excessive quantity, far oftener than inferior quality is the productive agent of the creeping tox

aemias which slowly poison the blood, befog the mind, choke the liver and put the kidneys on a schedule they can not maintain.

The morning head after a night of alcoholic excess is a "monster of hideous mien and familiar face" and some of us are on close terms with a similar monster after a season of epicurian excess, but we are prone to overlook the slow and stealthy step of liver and kidney degenerations resulting from prolonged over work. "Too much food, too little exercise." The voluntary muscles bask in ease, the involuntary are strained beyond their capacity. This condition can't continue. Headache is often a timely warning—an urgent summons to correct the errors—to increase the work or diminish the food.

"The mills of the gods grind slowly but they grind exceedingly small," and just so surely as we continue to eat and drink too freely, taxing digestion beyond necessity and elimination beyond endurance, we shall reap disaster. When headaches begin the harvest is often ripening. When this kind begin, lenses, rest cures and vaginal tampons will not avail. Medicines are poor substitutes for active exercise and temperance. In this connection (pardon if I seem to trespass unduly the narrow bounds of my subject) it seems to me we should urge all such patients to drink no water at meal time—thus attaining better mastication, they are satisfied with less food and then by encouraging them to drink abundantly of water between meals we flush the kidneys and render the work lighter by dilluting the urine.

(9) The head pain, fullness, stuffiness of constipation is probably some form of Toxaemia. It is frequent and often recognized by the patient. It is generally much aggravated by sudden movements, leaning over, straining, etc. The skull seems too small and the brain seems to throb and expand with every body motion.

(10) Nephritis Headache.—Most authors imply that the head pain of latent Nephritis can be easily recognized by the attendant somnolence, stupor, tremulous tongue, etc., and this may be true of

the kind accompanying threatened uremic coma, though 'tis far from true of those neuralgic hemicranical attacks which often precede for months or years any positive external manifestation of kidney involvment.

I well recall the case of my former Professor of Obstetrics. He suffered severely. Had lenses fitted, nose treated and it was half a year before he even suspected kidney complication.

Some of these cases are doubtless of the Arterio-sclerotic type, but I recall several where it was clearly a Toxaemia.

One of these was quite interesting. H. W., W. M. aet. 35, with negative history except syphilis ten years ago. Complains of periodic headache.

No probable cause was discovered and notwithstanding the pain was generally worse in morning—rather than in the night—he was given anti-specific treatment without effect. During one attack of special severity, the urine was found with a Spec. Gr. 1006—otherwise normal. Later observation demonstrated the paroxysms of pain were prone to follow any unusually full meal and were generally associated with low sp. gr. Later on the sp. gr. remained under 1.010 but only after three years did it show casts or albumen. The man is now forty-four and has a well developed Ch. Interstitial but by judicious regulation of daily habits he maintains a fair degree of health. Doubtless his is but one of many where the head pain is, for many months the only sign or symptom. In every case of recurring headache, whereever located and regardless of all other probable causes, the urine should be thoroughly and repeatedly studied. As one examination of sputa may fail to show bacilli—so may several urinalyses fail to reveal evidence of kidney disease. Repeated examinations are essential. And this is no less important in children than adults, as is shown by the following case.

Some two years ago a brother physician sent me a child of nine years with the message to refract her for headache. It was a plain

case of Hyperopic Astigmatism and suitable lenses afforded relief. But at the ophthalmoscopic examination a few suspicious spots about the macula were found—suggestive of albuminic retinitis. He examined her urine but found nothing abnormal excepting a very low sp. gr. Restricted diet and appropriate medication relieved her remaining headaches completely and she had fair health for several months—but four months later, without ever showing any other symtoms suggesting kidney involvment she suddenly went into coma and died on the second day. Such is often the history of Ch. In. Nepth. in children. I've seen it several times and remember hearing Dr. George Brown tell of a similar experience in a young boy of eight years. As a rule they show no sign other than headache or nausea till just before the onset of terminal convulsions or coma.

We suspect Chronic Interstitial Nephritis in the fourth and fifth decades of life but are prone to overlook it in children. Finally we must not overlook the head pain of brain fag—mental weariness. It is neurasthenia perhaps, but 'tis likely to lead a patient unconsciously to a drug habit. The pain is more often in vertex, associated with burning flashes of heat and other neurotic symptoms. Dim vision, spots before the eyes, emotional disturbances are often associated. To give coal tars and opiate here is little short of criminal.

Permit me to focus these scattering observations with the following conclusions:

1. The frequency of headache and its occasional severity render this an exceeding important symptom.

2. A thorough history of the patient, and especially of the duration, time of onset, associated symptoms, location of pain, aggravating circumstances, etc., will often enable us to exclude most of the causes and narrow a case down to three, two and sometimes one class.

3. A careful urinalysis should invariably be made in all severe, recurring cases.

4. Arterio-sclerosis, neurasthenia and excessive eating are prolific and much neglected causes of headache.

5. Excessive tax on any organs, mental, digestive, circulatory or sexual may produce this symptom, and it will not be permanently relieved till the excess is checked.

6. While the causes of headache are legion we can generally find the true one by patient study and when once found the suffering is easily and often certainly relieved.

7. The erstwhile "Sun-pain," the periodic headache, that heretofore was considered of malarial origin, is generally due to disease of some of the sinuses, and is not permanently relieved till these are properly drained.

8. The agents for temporary relief should be given the patient by the physician himself and always in small quantity. No written prescriptions should ever be given for anodynes. Caffeine, antipyrene, phenacetine and others of similar composition will relieve the pain from any cause—so would Morphia, but where once we write a prescription and the patient finds a relief is easy and the druggist sees it is profitable, the habit is easily begun and the doctor is "accessory before the act." These delusive drugs relieve for a transient period but repetition is essential and ere long your patient is a willing victim. They impair digestion, weaken heart power, pollute the blood in numerous ways lower the general resistive power. Like the fabled Spear of Achilles they ward off harm for a time but will kill in the end.

When the helpless sufferer has exhausted many sure cures, established vicious habits of drug taking and bankrupted his physical resistive power—the cause still operates, the headaches continue. For temporary use they are helpful, for cure they are worthless. As a postscript on a prescription "not to be refilled without order" is a delusion and avails nothing. If necessary give your patient a few tablets or powders of anodyne but let it be urged that no R for them be given.

HEADACHE.

J. N. Upshur in Medical News, calls attention to the headache "habit" and to the fact that large amounts of nostrums are sold to its victims. Many persons gradually become victims of chronic poisoning from the coal tar products which form the basis of all these remedies. He then notes the features characteristic of headache from some of the more common causes. Thus the headache from eye strain is situated over the brow and is persistent, extending in aggravated cases to the top of the head. Proper glasses continually worn give relief. The headache from gastric disturbances is diffused over the cranial vault, being most intense over the brow, gives a sense of tension and causes a distressing throbbing. Dizziness may result and there may be acid eructations. An emetic and free purgation relieve all symptoms, Renal headache presents a dull feeling over the entire cranium with more or less tendency to drowsiness, after scanty urine. Indications are plain. In acute lithemic states the pain is located in the temporal region, more commonly the left, the eyeball is sore to the touch and on movement in the orbit. The indications for treatment are dietic and hygienic. Reflex headache from uterine and ovarian diseases is very common. It comes on during the latter part of period or after the flow has stopped. The location of this form is in the occiput and down the back of the neck. The clavus hystericus located in the parietal region and more often on the left side is one of the intractable forms of headache. The area of pain is limited. Relief comes with the cure of the local uterine condition to which pain is due. The climacteric is often characterized by a sense of fullness, tension, sense of weight on the cranial vault, and a condition of unusual nervous irritability. Headache from various blood conditions is very common. The outcry of the nervous system for more nutrition in cases of anemia causes pain in the head, persistent but not intense, extending all over the cranium, and disappearing finally when the condition of the blood is improved. The specific headache of syphilis is intense, boring in character, and nocturnal in period of occurrence; the history of syphilis aids materially the diagnosis. It may be due to bone caries, or the development of gummata; in the former the boring character of the pain points to the bone involvment; in the latter, when they have sufficiently matured, we have evidence of irregular paresis.—Medical Record.

Abstracts.

CHRONIC AND RECURRENT COUGHS AND THEIR TREATMENT.

Abstract of article by J. E. Alter, M. D.

In treating coughs we quite often encounter obstinate cases, which, no matter what combative measures may be instituted, will continue without abatement. Such cases are best classified as the Chronic Cough and the Recurrent Winter Cough. Both of these classes are extremely obstinate in their course and yield reluctantly to treatment. They are usually of long duration, and while not, in themselves, directly dangerous, may become so by inducing emphysema and bronchiectasis.

In the great majority of chronic and recurrent winter coughs, the basic trouble lies in a low form of inflammation of the bronchial mucous membrane; especially that of the bronchioles.

In many cases I have used Codeia, but lately I have been having much more success with another derivative of opium, i. e., Heroin. In comparing the results obtained from the use of these two drugs, I notice that heroin will not constipate the patient, nor will it have the stupefying effect characteristic of codeine. Another advantage possessed by heroin is that it is effective in young children, in very small doses.

I had been accustomed to prescribe heroin alone, but, about a year ago, my attention was called to a preparation of that drug—Glyco-Heroin (Smith). Upon giving it a good trial I found that it gave me better results than obtained when heroin alone was given, and much more quickly. Glyco-Heroin (Smith) has one distinct advantage over plain heroin in that it can be given for a long time without ill effects, and in the class of patients in question this is, indeed, a most important feature. During the past year and a half I have treated a number

of cases and recurrent winter coughs with Glyco-Heroin (Smith) and have obtained uniformly good results.

Example.—A. L. Salesman. Aged 28. I saw this patient early in the spring of 1903. He is robust and of good habits. He consulted me concerning a constant cough which had troubled him for over a year. It was usually worse in the morning and after meals, and accompanied by expectoration of thick muco-purulent matter. Sometimes blood-stained, and especially so after a severe paroxysm. This circumstance preyed upon his mind considerably—he thought he had consumption. I learned that he had had a severe attack of acute bronchitis during the spring of 1902 and had been coughing ever since. Physical examination excluded tuberculosis. The diagnosis was chronic bronchitis, sequential to acute. The patient was immediately put on Glyco-Heroin (Smith), and the same hygienic measures ordered as in case 1. Here again the financial condition of the patient precluded change of climate. In addition to the Glyco-Heroin (Smith) the patient was given syrup of hypophosphites as a tonic. I did not see him again until last October. He then reported himself absolutely free from cough. He continued taking the Glyco-Heroin (Smith), and, during the present winter, has not experienced any return of the trouble. In this case a complete cure was effected by means of quieting the cough and stopping the irration of the mucous membrane, in this manner allowing the restorative powers of the body, aided by the tonics and good hygiene, to accomplish a cure.

Example.—Miss R. M. Aged 24. Teacher. This lady had been coughing ever since she was nineteen years of age. At that time she had had an attack of rheumatism with a complicating bronchitis. After the acute condition had moderated, she continued to cough, the cough being very annoying in character, spasmodic and prolonged. After each paroxysm she was left in a state of exhaustion. During the attacks she urinated involuntarily. On examination she was found to have chronic bronchitis, aggravated by an exceedingly irritable condition of the respiratory tract. The mere odor of cigar smoke was

sufficient to induce a paroxysm of coughing. In treating this patient it was necessary to devote attention to the neurasthenia as well as the chronic bronchitis. She was placed on a diet and her mode of living regulated. Arsenic, strychnine and iron in pill form were given. For the cough, I ordered Glyco-Heroin (Smith). The improvement was marked and rapid. The general nervous condition became much improved and the cough grew much less severe and gradually lost its spasmodic character. At the present time it amounts to but little more than a "clearing of the throat." This case, more than any other, demonstrated the excellent properties of Glyco-Heroin (Smith). The quick relief afforded was surprising and no more gratifying to the patient than to me.

LATENT RHEUMATIC CONDITIONS.

By J. R. Phelan, M. D., Oklahoma City, Okla., Editor Oklahoma Medical News Journal.

It is during the spring months more particularly that the physician is called upon to treat patients, who though not ill enough to be in bed, are not at all well. Their appetite is capricious, they sleep indifferently, or even if they sleep soundly they are not refreshed, and in the morning they are almost as fatigued and ill at ease as was the case on retiring. Upon awakening there is frequently an aching sensation in the loins, sometimes in the lower limbs, which may partially wear off as the day progresses, but there is at all times a vague, undefined, uneasy painful feeling.

The symptoms are very like those experienced in malaria, but the causes are entirely different and a different treatment is necessary.

This condition arises from the fact that in the spring the eliminative functions do not present their usual activity owing to the torpor and locked-up secretions which have existed during the winter months, when the skin neglects its duties and the kidneys are overworked.

If the condition remains neglected the probable result will be sooner or later a pronounced attack of rheumatism or grippe in one or anoth-

Glycozone

Is daily making converts among physicians for its wonderful work in

INFLAMMATORY AND CONTAGIOUS DISEASES OF THE ALIMENTARY CANAL.

It is the rational treatment in Gastric and Intestinal Disorders, such as Dyspepsia, Gastritis, Gastric Ulcer and all Contagious and Inflammatory Diseases of the Stomach and Intestines.

Full particulars with clinical reports on cases — in my book: "The Therapeutical Applications of Hydrozone and Glycozone"; Seventeenth Edition, 332 pages. Sent free to physicians on request.

Prepared only by

Charles Marchand

Chemist and Graduate of the "Ecole Centrale des Arts et Manufactures de Paris" (France)

57-59 Prince Street, New York

The one distinctive feature of

Gray's Glycerine Tonic Comp.

is its uniform efficacy in debilitated patients of all ages---the child, the adult, the aged. It improves the appetite, creates digestive vigor, promotes assimilation and---most important---has no deleterious after effects.

Gray's Tonic has become the standard remedy for anaemia, malnutrition and nervous exhaustion, from whatever cause.

THE PURDUE FREDERICK CO., 298 Broadway, N. Y.

Editorial.

JNO. C. LeGRANDE, M. D.,.....Editor and Prop

COLLABORATORS:

T. W. Ayers, M. D., Hwang-hien, via Chefoo, China.
J. T. Searcy, M. D., Tuscaloosa.
L. C. Morris, M. D., Birmingham.
J. A. Goggans, M. D., Alexander City.
W. W. Harper, M. D., Selma.
Frank T. Smith, M.D., Chattanooga, Tenn.
E. D. Bondurant, M. D., Mobile.
B. L. Wyman, M. D., Birmingham.
Thomas D. Parke, M. D., Birmingham, Ala.
W. H. Wilder, M. D., Birmingham,
D. F. Talley, M. D., Birmingham.

The Journal will be mailed on or about the 15th of the Month. Subscribers failing to receive it promptly will please notify us at once.

We cannot promise to furnish back numbers

SUBSCRIPTION $2.00 A YEAR, IN ADVANCE

The editor is not responsible for views expressed by contributors.

All communications should be addressed to THE ALABAMA MEDICAL JOURNAL, Birmingham, Ala.

In Memoriam—Dr. John Clark LeGrande.

It is with much sorrow that we have to announce the sudden death of Dr. John C. LeGrande, the editor and proprietor of this journal, which occurred at his home in this city on the morning of March 21st.

His death came rather unexpectedly and was a great shock to his many friends and to the community. It had been known for the past

positive diazo-reaction, and the occurrence of rose spots and the anamnesis. The other signs and symptoms were much less constant, the typhoid tongue and the temperature curve apparently being least significant of all. It is rather strange that he failed entirely to take into consideration the leucopenia and the relative leucocytosis. To be of use, the number of cases studied (sixty) was too small to justify any hard and fast conclusions. They are none the less suggestive.—Munch Med Wochens.

A CASE OF CERVICAL RIB, WITH SYMPTOMS RESEMBLING SUBCLAVIAN ANEURYSM.

J. B. Murphy states that cervical rib does not usually develop until adult life. In patients requiring surgical attention, it usually arises from an individual ossific center. It increases in diameter with its distance from the spine. In some cases it develops beneath and behind the branches of the brachial plexus, and carries the nerve trunks forward with the subclavian artery above it, so that the pulsation of the latter is the first conspicuous sign of trouble. The end of the rib compressing the nerves or artery against the lower portion of the scalenus anticus, causes in the former case severe pain and occasionally paralysis of the brachial plexus, and in the later an endarteritis or thrombosis, with gangrene or aneurysm. Edema is absent, as the vein is not compressed. The supernumerary rib exists on both sides in 67 per cent of the cases found. The relation of the scalenus muscles to the artery, nerve and rib, and its effect as a counteracting force, have not, up to this time, been appreciated. The case reported is interesting on account of the severity of the symptoms before operation, and their prompt subsidence after removal of the rib. All patients should be operated on as soon as diagnosed. The periosteum should be removed with the rib, otherwise the latter might be reproduced.—(H. M.)

THE POPE AND THE MIRACLES AT LOURDES.

Dr. Boissaire of Lourdes, France, sent recently, as usual, his annual report to the Pope of the miraculous cures effected at the famous grotto of Lourdes in his charge. He received, in reply, a letter from Dr. Lapponi, the medical attendant of the Pope, stating that in future the latter wishes to have arrangements made to establish the identity of the persons thus cured, with depositions of physicians and witnesses who had seen the patients before their cure, placing the Lourdes experiences on a more sceintific basis than hitherto.—A. M. A., Jan. 27, '05.

"THE CHUNNENUGGEE" DR. SEALE HARRIS' PRIVATE SANATORIUM

FOR THE

TREATMENT OF DISEASES OF THE STOMACH, INTESTINES AND NERVOUS SYSTEM

Isolated apartments for the treatment of ALCOHOL, MORPHINE, and other DRUG ADDICTIONS. We are especially prepared for the DIAGNOSIS OF TUBERCULOSIS. Insane patients and epileptics are not received. Sanatorium is fully equipped with modern appliances for the treatment of the above mentioned diseases—X-ray and static machine, faradic, galvanic and high frequency electrical outfits, vibratory massage, etc. For rates and other information, address

DR SEALE HARRIS, Physician in Charge,
or DR J. L. BOWMAN, Resident Physician,
Union Springs, Ala.

WHEELER'S TISSUE PHOSPHATES.

As Reliable in Dyspepsia as Quinine in Ague.

Palatable, Delicious. Never Palls on the Patient.

The Ideal Reconstructive and Haematinic.

T. B. WHEELER, Montreal, Canada

Send for Literature Samples no longer furnished.

L. & N.

Louisville & Nashville R. R.—The Great Through Car Route.

Double Daily Line of Pullman Palace Sleepers from Montgomery to Louisville and Cincinnati, Mobile and New Orleans, making direct connections for the **North, East, West and South.**

For information as to Rates, Routes, etc., see agent of the company, or write to
R. F. BEASLEY, Pass. Ag't, Birmingham, Ala

er of its forms. All that is needed to induce such an attack is a sudden change in the weather or the exposure on the part of the patient to cold or wet or to a combination of both. This is due to a latent rheumatic diathesis to which every adult is liable.

The necessity of a powerful eliminant in every prescription for rheumatism and grippe is self--evident. While anti-pyretics and anti-periodics may slightly stimulate the excretions and relieve congestion thereby controlling certain features of the disease, a complete cure cannot be expected until the poisons are thoroughly eliminated from the system and the diseased organs enabled to resume normal functions.

In the treatment of all rheumatic, neuralgic and grippy conditions, Tongaline, by promoting the absorptive powers of the various glands which have been clogged, and by its stimulating action upon the liver, the bowels, the kidneys, and the skin, will relieve the pain, allay the fever, eliminate the poisons, stimulate recuperation and prevent sequelae.

THE CAUSES OF SUDDEN OR RAPID DEATH IN PNEUMONIA.

Ferrien (Revue mensuelle des maladies de l'enfance) discussing the causes of sudden death in children with pneumonia summarizes as follows:

1. Extra pulmonary localizations are frequent, especially before the age of two years. Pericarditis, usually suppurative, is frequently encountered. It is often latent and may determine rapid death.

2. Sudden or rapid death may be observed at every age with or without extra pulmonary localization; it is, fortunately, not a frequent accident. This possibility, in a certain degree, allies pneumonia of the child with other affections, such as diphtheria and typhoid fever, in which sudden death has been observed.

3. Cyanosis is often the first sign which reveals the imminence of a fatal termination and may be an indication of a pericarditis or of a simple acute dilation of the heart,

Selected Articles.

THE VALUE OF THE VARIOUS CLINICAL SYMPTOMS FOR THE DIAGNOSIS OF TYPHOID FEVER.

In the past two years Treupel has studied sixty cases of typhoid fever with great care and in great detail. Many of them atypical in one way or another—indeed, few of them showed the characteristic symptom-complex in its completeness. His results may be briefly tabulated as follows:

1. A typical typhoid tongue appeared in 16.7 per cent.
2. The temperature curve was characteristic in 46.7 per cent.
3. A well-marked bronchitis was found in 48.3 per cent.
4. A feeling of comfort out of all proportion to the fever in 56.7 per cent.
5. An angina was present in 58.3 per cent.
6. There was abdominal discomfort (meteorism, etc.) in 61.7 per cent.
7. Roseola in 71.7 per cent.
8. Positive diazo-reaction in the urine in 73.3 per cent.
9. The previous history suggested typhoid in 75.0 per cent.
10. A pulse slow, out of proportion to the temperature, in 86.7 per cent.
11. A distinct splenic tumor appeared in 86.7 per cent.
12. The Widal reaction was positive in 90.6 per cent.
13. Typhoid bacilli were found in the blood in 92.8 per cent.

These figures are of considerable interest. The two most constant signs were a positive Widal and the cultivation of typhoid bacilli from the blood, the latter not only being more constant than the former, but being positive earlier in the disease. Next in importance came the splenic tumor and the slow pulse, followed by

year that he was in poor health and it was very evident to his friends that he was gradually declining in strength and vigor, but no one anticipated the sudden change which came. He had been attending regularly to his professional work and was at his office as usual only a few days before the end, so that it may be said of him that he died practically in the harness. The cause of his death was leucaemia, the disease with which he had been suffering for more than a year.

For many years Dr. LeGrande has been a conspicuous figure in the medical profession in the State and has exerted a wide influence and his death is a distinct loss to the profession as well to this journal, which he founded and conducted successfully for the past eighteen years. He was admired and esteemed for his many excellent traits of character, and in his death medical journalism in the South has lost one of its most active and earnest workers. He occupied many high positions of honor and trust bestowed upon him by his professional brethren and he filled these places always with credit to himself. For many years he has been prominent in medical organizations both National and State, having filled the chair of Vice-president of the American Medical Association, President of the Medical Association of Alabama, President of the Tri-State Medical Society of Alabama, Georgia and Tennessee, and since 1902 Secretary and Treasurer of the Birmingham Medical College and Professor of Obstetrics. In his official capacity as secretary of the faculty he had much to do in shaping the policy and destiny of the institution. Entering upon college work upon the reorganization of the faculty when a new building was to be erected, he devoted much time and labor in building up and increasing the usefulness of the institution. He was always the friend and counselor of the medical student, and by his many acts of kindness endeared himself to the young men and at all times manifested

Pages 206-210 printed backward.

a deep interest in whatever pertained to their welfare. Beginning life with comparatively few advantages, he surmounted the many difficulties which confronted him in his early professional career and by force of energy, determination and high purpose he forged his way to the front and achieved success in his chosen profession. If there was one trait which characterized him more than another it was his kind heart and his love for his fellow men. He was a genial and friendly man of dignified bearing and was uniformly courteous with those with whom he came in contact, and with it was a man of firmness and decision of character. In his death his children have lost a devoted father, the State of Alabama a good citizen, the medical profession an earnest, conscientious physician; one who was true to every trust and relation in life.

For many years he devoted considerable time and attention to the management of this journal, which has been the exponent of the best thought of the profession in the State. The Jefferson County Medical Society, which he attended regularly and was an enthusiastic member, held a memorial meeting on March 26th. Upon this occasion many beautiful tributes of respect were paid to his memory. We deplore his untimely death and to his children offer our sincere sympathy in this time of their sore bereavement.

We desire to announce to the friends, subscribers and patrons of the Journal that its publication will be continued, the control and management being placed in competent hands.

Memorial Meeting of Jefferson County Medical Society, March 26, 1906.

John Clarke LeGrande, M. D., was born in Calhoun county, Alabama, Dec. 6, 1854; died March 21, 1906, in Birmingham, Ala.

Between these two dates is embraced the life of a man of tireless

home coming was always looked forward to with pleasure, and his presence in the family circle was sunshine and pleasure. He was the type of Christian gentleman in word and work.

As a physican he was an earnest, zealous worker, loyal and active in every effort that looked to the promotion of his profession. As an active practitioner of medicine he was ever deferential and kind to all worthy practitioners with whom he came in contact, and so demeaned himself as to win the confidence and esteem of his patients. The high regard in which he was held by his professional brethren is amply manifested in the honors conferred upon him by the various medical organizations with which he was connected. Notwithstanding the many obstacles met with in his life, Dr. LeGrande moved on to success, marked with distinction not the heritage of an ordinary man.

He has been taken from us. "Love to his memory," "Peace to his ashes."

Dr. Mack Rogers said: I would be recreant to my feelings did I not express my high esteem for Dr. LeGrande. I have known him rather intimately for a number of years, and in all our associations have found him thoroughly honest, strictly ethical, and above all a Christian gentleman.

Not long before his death I had occasion to speak to him concerning religion, and I am happy to say, he impressed me profoundly by his simple firm faith in the abiding grace of God. If I should say one of his sterling traits of character outranked all others, it would be gratitude. His loyalty to his family, church, profession and friends was always an inspiration to me. Duty, to him, was a thing ever to be conscientiously discharged. Many has been the time he has approached me with duty and expediency in deadly conflict, but always holding duty uppermost and foremost in the controversy.

His loyalty to the Medical profession was no less than to other things that lay close to his heart. He was always the staunch friend, wise counsellor and supporter of organized medicine. I have known

him often to attend medical meetings when he was not actually physically or mentally able to do so.

In conclusion I wish to say, this Society has sustained a distinct loss, the State Association a loyal and enthusiastic member, and the American Medical Association one of its most distinguished Vice-presidents. Our Medical College has lost one of its founders and firmest friends, his family a fond and affectionate father, and his church a consecrated Christian.

Dr. J. D. S. Davis said: The role Dr. LeGrande has performed should be a great comfort to his family and an inspiration to every poor struggling medical student. He began medicine without that preparation which a good education affords; and his early career was one of great hardships, struggling toil, and constant privations. Dr. LeGrande had more than the ordinary success which comes to a physician.

He removed to Anniston early in his professional career that he might have better opportunities for work and a wider field for usefulness. For the same reason he came to Birmingham. He was in the fore-rank of every cause which looked to the elevation of his profession and the good of humanity. Honest to a fault he could always be placed on any question. He was not a "fence-straddler," but was on one or the other side of every question, and when he took a stand on any cause he became a champion of vigor, who feared no foe, and would run counter to friends to follow his convictions.

When Dr. LeGrande founded the Alabama Medical Journal he took upon himself a responsibility that few men would voluntarily shoulder. The lamented Cochran once said that he hoped some progressive man with brain and courage would publish a medical journal in the state, as the job was too big an undertaking for him. We all know how well Dr. LeGrande succeeded! He went into it welcoming infinite details and unknown responsibilities, and met every obligation promptly, cheerfully and successfully. Nothing else he ever undertook gave me such a paradigm of his ambitious determination to do

Dr. B. L. Wyman said: I cannot allow this solemn occasion to pass without speaking a few words of tribute to the memory of my departed friend and colleague whose life and character have been so beautifully portrayed in the memorial just read by Dr. Sholl, the chairman of the committee. I have been intimately associated with Dr. LeGrande for a number of years, especially since his removal to Birmingham in 1899, and I think I knew him as well as any man in this Society. I have always held him in high esteem on account of his many sterling traits of character. He was a straightforward, kindly man of dignified bearing, of the strictest integrity, firmness and decision of character. As a physician he was conscientious, painstaking and devoted to his patients, and was strictly ethical in all of his relations with his professional brethren. Educated in the country schools of Calhoun, his native county, he did not have the early advantages of a collegiate education, and reached his maturity with little more than a common school education. Being ambitious he decided to begin the study of medicine and matriculated at the Atlanta Medical College graduating from that institution in 1880. At that time the Southern Medical Colleges did not afford very superior advantages, so that he lacked the early professional training which is so essential to success in the medical profession. Notwithstanding these disadvantages, by the force of energy and perseverance he surmounted the many difficulties which confronted him in the beginning of his professional career and in a few years achieved a prominent place in his profession.

In his life he exemplified what can be achieved by the self-made man. He assisted in organizing the Calhoun County Medical Society and was the Secretary for a number of years and later was elected President. He early became an active and enthusiastic member nd supporter of the Alabama State Medical Association and was elected a Counsellor at Mobile in 1889, and in 1899 was elected President of the Association, presiding over the meeting held in Montgomery in 1900. In addition to these honors he was elected Vice-president of the American Medical Association at the meeting in Baltimore in

1895, and presided in Atlanta over the meeting of the Association during the greater part of the session held in June, 1896. In 1901 he was elected President of the Tri-State Medical Society of Tennessee, Georgia and Alabama, at Nashville, Tenn., and presided at the meeting in Birmingham in 1902.

In all of these high positions of honor and trust, he was faithful loyal and true to the organization which he represented. He was a firm believer in medical organization and did much to further the best interests of his profession.

He was perhaps better known in connection with medical journalism having founded and conducted successfully the Alabama Medical Journal for the past eighteen years. He was an untiring worker in this field and was foremost in every movement for the elevation of his profession and the good of humanity.

In 1902 he became actively connected with the Birmingham Medical College, having been Secretary and Treasurer and Professor of Obstetrics. Both of these positions he filled with credit to himself, and as Secretary of the College had charge of its business affairs and was largely instrumental in shaping and directing its policy, to which he devoted much time and attention. In common with his many friends I greatly regret his untimely death. I shall always remember him as a true and loyal friend.

Dr. T. L. Robertson said: Perhaps I have been acquainted with Dr. LeGrande longer than any one else in this hall. I have known him for about thirty years, and much of this time intimately. Even were I capable it would be unnecessary for me to attempt an extensive eulogy on a life so familiar to almost every member of this Society.

Dr. LeGrande was a man of high ideals, proud, ambitious to succeed in all his efforts both professional and otherwise. He was a model of honesty and integrity, charitable in disposition, ever ready to forgive a wrong, and to acknowledge an error. As a husband and father he was the very essence of kindness and faithfulness. His

activity, who stepped over the limitations of an apparently narrow career to walk on the highways of a successful life. His person was the translation of his name: tall, upright in stature, strikingly noble and dignified in manner and appearance, of such bearing as everywhere to attract attention, gentle, courteous and gracious in bearing, it is no wonder that he won to himself ardent and affectionate friendship of those who knew him best. Kindness was the law of his nature which he carried into the differences of men who think for themselves. Firm in his opinion where he conceived principle to be involved, ready and forceful in debate, vehement at time as he had the courage of his convictions, it was always with a temper under control and a spirit of concession to those with whom he differed. Graduating in 1880, he early brought the resources of an active mind to his professional work, which during the later years of life brought to him all the honors conferred by his brethren which the most ambitious mind could crave and which were won because they were deserved and merited because he was worthy of them.

If we stop to ask the ultimate reason why all these honors crowned a comparatively short career, the best answer that can be given is that he was at all times and at all places absolutely loyal to his profession. He translated the highest conception of ethics into his daily life; the way was naturally plain to him and he rigidly followed it, because he knew it was right and because all devious ways were foreign to his every thought.

Let us see what came to him in the twenty-five years of his professional life. He helped to organize, as a charter member, the Calhoun County Medical Society, and was for nine years its Secretary; elected Counsellor of the State Medical Association in 1889; in 1896, Vice-President of the American Medical Association; in 1899, elected President of the Medical Association of the State of Alabama; in 1891, President of the Tri-State Medical Association. In all these positions he served with active efficiency. For eighteen years he had been the editor and proprietor of the Alabama Medical Journal, and

through its pages the bright minds of the profession of the State gave their best thoughts and experiences, the practical and far-reaching effect of which cannot be measured, as they embody themselves into the active work of many professional lives. His editorials were often forceful, and when any question of ethical right and loyalty was involved, uttered no uncertain sound. He had an abiding faith in the upward progress of our profession on its best lines of associated work, and to it his pen and action were always rigidly adherent.

His work as Professor of Obstetrics in the Birmingham Medical College which he very capably filled,—his responsible position as its Secretary and Treasurer, added to the fullness of a busy life.

Long a devoted member of the Methodist Church, he carried into his daily life an exemplification of its precepts, and in accordance with his means was a liberal giver to any worthy cause.

A life of success gained by diligent and faithfully applied work should be an inspiration to the younger men of our profession for honors fairly won and worn; for those thus earned should be the legitimate ambition of every noble mind. They are open to all, for

"Honor and fame from no condition rise;
Act well your part,—there all the honor lies."

Drawing such lessons as this life teaches, let our own aspirations best comport with those purposes, that shall be a daily benediction to every life that we cross in our chosen round of duty.

"Life a slight shadow is,
For if it long appear,
When it is most in sight,
It steals away and none knows how or where,
So near our cradles to our coffins are."

Resolved that a copy of this memorial be entered upon our records, that a copy be furnished to the family of our deceased brother, to the Alabama and Mobile Medical Journals, and to the daily papers of our city.

E. H. Sholl, M.D.,
J. D. S. Davis, M. D.,
D. F. Talley, M.D.,
Committee.

something and be something of a factor in the progressive advancement of his profession.

My personal association with Dr. LeGrande was always pleasant and profitable. I have traveled with him, eaten with him, and slept with him. I have seen him in all the moods common to him, and I must confess he was a man of unquestioned honor, whose loyalty to friends never failed, and whose patience with and justice to enemies could not be excelled.

I have seen him in sorrow, like the mighty oak, in the midst of storms and lightnings of misrepresentation, torn, pained and scarred, yet he could not be felled, and with the spirit of a God-like man he pursued the even tenor of his way.

I believed in his honesty of purpose and sincere piety so strongly that if he could be called back from the better land, where no physicians are needed, I am sure he could say he had done the best possible with the lights before him.

May we all emulate his virtues and his graces.

Dr. Morris said: I feel gentlemen, that I cannot let this opportunity pass without adding my tribute to the memory of our departed brother. It is indeed inspiring to listen to such remarks as we have heard tonight, and such an occasion as this should act as an inspiration to each one of us.

Success in its highest and purest sense is the appreciation of, and the recognition of one's ability and merit by those who are most competent to judge. Dr. LeGrande's life shows that notwithstanding almost insurmountable obstacles he measured up to this standard as exemplified by the many positions of honor and trust bestowed on him by his brother physicians.

Among Dr. LeGrande's most attractive traits of character was his unwavering loyalty. Those of us who knew him best had frequent opportunities of observing this. Another of his strongest characteristics was his charitable attitude towards the shortcomings of others. I don't think in all my intercourse with Dr. LeGrande that I ever

heard him criticise harshly or utter an unkind remark about any of his brother physicians.

The Jefferson County Medical Society has lost a loyal, earnest worker and we have lost a friend and colleague.

The State Medical Association.

The approaching meeting of the State Medical Association of Alabama which convenes in this city on April 17th promises to be one of the largest and most important in its history. There is much business of great interest to the profession to be transacted. The new constitution submitted at the last annual session comes up for adoption and it is expected that there will be a free and full discussion of many of its provisions. We have not the space in this issue to discuss in detail some of the more important sections which have been revised. We understand, however, that there is some opposition in certain quarters to the adoption of some of the new sections. Undoubtedly the old constitution at the time of its adoption was an excellent one but it had outgrown its usefulness and needed revision to bring it up to date. It has been intimated that there is a strong sentiment among some of the members of the Association to limit the power of the Senior Censor and the State Board and also to abolish or limit the powers of County Boards of Examiners. These are very vital questions affecting the future of the Association and cannot be discussed in a short editorial. Our State Organization has been regarded as a model for many years and it is the opinion of the writer that we should go very slow in making any radical changes. It has been claimed by some that it is not a democratic organization, that individual members of the profession in the State are taxed without

proper representation. This is not a valid objection or one which should be seriously considered as each County Medical Society is entitled to two delegates to represent its interests besides the counsellors who are distributed throughout the various congressional districts in numbers according to the number of members of the County Societies in the several districts. What more representation could be asked or expected. The old guard will stand by and fight to the last ditch for the Association as at present organized and the writer predicts that they will win and that no important changes will be made.

The Jefferson County Medical Society have arranged a number of social entertainments for the members of the Association and the meeting will prove a notable one in many respects. We hope that there will be a full representation of physicians throughout the State. Birmingham will give them a most cordial welcome and can promise all who attend a good time.

The following doctors while in attendance at the New Orleans Polyclinic made a trip to Central American ports as Marine Medical Inspectors on fruit steamers for the Louisiana State Board of Health: Dr. O. Patton, Midway, Tex.; Dr. J. H. Buckley, Ft. Smith, Ark.; Dr. T. R. McClellan, Gainesville, Ala.; Dr. A. Aiken, Dewalt, Tex.; Dr. R. H. Harrison, Alleyton, Tex.; Dr. G. W. Cross, Brownwood, Tex.; Dr. T. P. Bell, Washington, D. C.; Dr. A C. Miller, Waxahachie, Tex.; Dr. V. H. Caine, Demopolis, Ala.; Dr. J. W. Phillips, Zimmerman, La.; Dr. J. C. Davis, Tundra, Tex.; Dr. A. H. Speer, Madisonville, Tex.; Dr. W. P. Moore, Culleoka, Tenn.

Miscellaneous Notes.

It has been positively determined that the agent which uniformly and unfailingly neutralizes and counteracts the rheumatic virus must be a natural product and not a synthetic one.

Oil of wintergreen contains 96 per cent. of methyl salicylate and a recognized authority has stated that he had never seen cyanosis follow the use of the salicylates from the natural oil, but only when the synthetic acid was used.

In the administration of the salicylates it is of the greatest importance that the acid should have been derived from the natural oil of wintergreen, which is the only kind of salicylic acid used in Tongaline.

STUBBORN CASES OF RHEUMATISM.

Many stubborn cases of rheumatism respond rapidly to the influence of "Tongaline." This product, representing the highest degree of pharmaceutical skill, contains the salicylates in an unusually potent form, in as much as they are not obtained by synthesis, but are extracted from the purest oil of wintergreen. In addition to their potency as anti-rheumatics they possess an additional advantage in not deranging the most sensitive stomach.

Physicians who appreciate the progress of honest pharmacy will find in "Tongaline" a product worthy of their highest commendation and confidence.—International Journal of Surgery, February, 1906.

In the spring the eliminative functions do not present their usual activity owing to the torpor and locked-up secretions which have existed during the winter months when the skin neglects its duties and the kidneys are overworked.

If this condition remains neglected, the probable result will be a

pronounced attack of rheumatism, neuralgia or grippe in one or another of its forms, hence the necessity of a powerful eliminant is self-evident.

While anti-pyretics and anti-periodics may slightly stimulate the excretions and relieve congestion, thereby controlling certain features of the disease, a complete cure cannot be expectd until the poisons are thoroughly eliminated from the system and the diseased organs enabled to resume normal functions.

Tongaline by promoting the absorptive powers of the various glands which have been clogged and by its stimulating action on the liver, the bowels, the kidneys and the skin, will relieve the pain, allay the fever, eliminate the poisons, stimulate recuperation and prevent sequelae.

CHICAGO'S MILK SUPPLY.

Chicago's milk bill during November averaged upward of $85,000—nearer $86,000 per day.

That is to say: 20 railroads brought into the city every day during the month an average of 1,011,180 quarts of milk and 53,220 quarts of cream—which, at 7 cents a quart for milk and 28 cents a quart for cream, was consumed in Chicago at a daily cost of $85,684.20.

Following the restriction of milk inspection, caused by the disruption of the Department Laboratory in September—a reduction in the work of fully 60 per cent—the number of watered samples increased from 2.07 in every hundred during October to 6.16 in every hundred during November.

Which means that, while the housekeepers of Chicago paid only $1.980 a day for water in their milk and cream during October, they paid $5,278 a day for the increased adulteration of November. This amounts to a net of $96,280 during a single month—a sum ample to move and equip a half dozen laboratories.—Health Department Bulletin.

AN IMPROVED METHOD OF TREATMENT IN GLAUCOMA.

K. Scott (Caledonian Medical Journal) records a modification of the operation of iridectomy, which he thinks will prove of service in the treatment of glaucoma. An iridectomy as usually performed for glaucoma is the excision of a large piece of iris from the pupillary to the attacked margin. This is liable to open freely the filtration angle, but at the same time, by breaking the continuity of the sphincter of the iris, prevents any reflex contraction. Scott thinks that we may be able to compass a free opening of the filtration angle, and at the same time spare the sphincter; thus, "By making a full incision in the iris, which removes the outer portion only of a sector of tissue, up to the ciliary insertion of the radiating fibres of the muscle, and leaves the fibres composing the sphincter of the pupil aperature quite intact; therefore the full action of the latter remains unimpaired for all practical purposes."

CRITICISM.

A reader, well versed in French, takes exception to my le's and la's, and calls attention to an error which he believes he has caught me taking with my genders when saying Vive la Mariani! which, by his interpretation, makes Mariani of the feminine gender. But nothing could have been further from my wish, for Mariani is of all men an exceptional type of manhood, and fully entitled to be so engendered. In this expression of long life to Mariani, the individual was not intended, but the subject which he qualifies was in mind, that is Coca. For all the world knows that Mariani has made Coca synonymous with his name. Mariani, then, stands for Coca, and Coca means Mariani. The rest is with the French lexicographers, who, having made Coca of the feminine gender, enable us to rightly express the heartfelt wish —Vive la Coca! implying also Mariani, or Coca, as you will, and thus affording a pretty play on terms by way of courtesy. So then I say, Vive la Coca Mariani! Vive Mariani!—Editor of Coca Leaf, January, 1905.

SYRUP TRIFOLIUM COMPOUND WITH CASCARA—AN EFFECTIVE COMBINATION OF AN ALTERATIVE WITH A LAXATIVE.

The superiority of Syrup Trifolium Compound with Cascara must be apparent when its composition is noted. Each fluidounce contains the active constituents of Red Clover Blossoms, 32 grains; Lappa, 16 grains; Berberis Aquifolium, 16 grains; Xanthoxylum, 4 grains; Stillingia, 16 grains; Phytolacca Root, 16 grains; Cascara Amarga, 16 grains; Potassium Iodide, 8 grains, and Cascara Sagrada, 40 grains. The dose is from one to two teaspoonfuls, three times a day.

While it is particularly indicated in the treatment of secondary syphilis, with or without mercury, Syrup Trifolium Compound with Cascara commends itself as a general alterative. In skin diseases it evidently stimulates the action of the emunctories, adjusts the balance of waste and repair, and produces marked improvement. Many eruptive diseases are aggravated by constipation, induced by sedentary habits, and in such cases Syrup Trifolium Compound with Cascara P. D. and Co. may be regarded almost as a specific. While regulating the bowels and restoring natural peristalsis, it continues to exercise its alterative effect, which is enhanced by the elimination of waste products. In psoriasis and eczema it may be found effective when other measures produce indifferent results.

In strumous cases its favorable effect may be supplemented by combinations of iodide of arsenic, bichloride of mercury, sulphide of calcium, or iron. As it is easily borne by the stomach and pleasant to the taste, it may be taken by children for a long time without giving rise to derangement of the stomach or producing nausea.

It also proves useful as a vehicle for calcium iodide in the acne of adolescents; iodide of mercury in specific ulceration of the fauces; and for the administration of large doses of iodide of potassium in tertiary syphilis. In anemia, chlorosis, amenorrhea, etc., the most favorable results are produced by alternating it with some iron preparation.

THE DANGERS OF ILLUMINATING GAS.

Illuminating gas has become of very general use, especially among the poor. It is now not only the poor man's light, but it warms his home, and it cooks his food as well. It is, therefore, nearly cause for wonder that comparatively few deaths are attributable to the careless use of it. Formerly the danger was not so great, for it was "coal gas," and the characteristic odor was a danger signal. But the modern "water gas," which has so largely replaced it, with its larger content of carbon monoxide, and its comparative lack of odor, is far more dangerous. Leffmann (Journal A. M. A., June 3) finds that carbolic acid and illuminating gas have replaced, in Philadelphia at least, the suicides and accidental poisonings, the arsenic and laudanum of the Civil War period. A very small percentage of carbon monoxide—less than one-half a grain to 100 c. c. of blood—can render useless its haemoglobin; so that a sleeper can easily absorb a fatal amount of modern water gas without being aroused. Gas cooking stoves are used generally only in warm weather, when there is good, natural ventilation: but their burners are seldom furnished with a collar to regulate the air supply, and the combustion is therefore liable to be irregular, and deleterious gases are given out. There is often serious leakage from the tubing, unless the best material is used. The stopcock on the heater is especially objectionable, being the one most convenient to use; and when used the leakage through the tube can go on unchecked. Leffmann advises that the sale of inferior tubing be prevented; that there should be no stopcocks on heaters unless they are connected to house mains by metal pipes, with tight joints and such construction as will prevent the rubber tube, even when of the best quality, remaining in free connection with the house main when the gas is not lighted. Heaters should be so constructed as to give a large radiator effect with a given gas consumption; and they should be placed only where the products of combustion can escape freely from the chimney. All burners on the Bunsen principle should be provided with collars to regulate the air supply, and purchasers should be instructed in their use.—Exchange.

DEIMEL LINEN-MESH SYSTEM CO.

Catching cold is an indication of an impaired activity of the skin, and occurs most frequently with people of weakened capillary circulation, the result of wearing woolen undergarments.

Such affections as catarrh, bronchitis and pneumonia are traceable to the same predisposing cause. The retention of waste material, attending the wearing of woolens next the skin gives rise to inflammatory diseases of internal organs, including Bright's disease.

A change to the Dr. Deimel Underwear is usually followed by immediate results for the better. The skin, heretofore covered with a clammy layer of unabsorbed perspiration and debris, assumes a normally dry and elastic condition. It is, so to speak, toned up. Exposure is not felt so much, nor is it followed by attacks of cold; catarrhal and rheumatic tendencies disappear and the danger of pneumonia is greatly lessened. Within a short time the wearer wonders at the marvelous change for the better which has taken place in his general health, and is surprised that he ever could have worn woolen underwear.

CYSTOGEN-LITHIA EFFERVESCENT TABLETS.

The many indications for the use of lithia in combination with cystogen have resulted in the preparation of cystogen-lithia effervescent tablets. Physicians will find these tablets of special value in the treatment of many conditions suggesting the addition of lithia as increasing the efficiency of cystogen. In rheumatism, gout, urinary deposits, ammoniacal urine, cystitis, etc., cystogen-lithia hastens the excretion of urates and uric acid and prevents the formation of calculus. These tablets are composed of cystogen 3 grains, lithium tartarate 3 grains; usual dose, one to two tablets three or four times daily dissolved in half a glass of water. Samples will be sent to physicians addressing the Cystogen Chemical Company, St. Louis, Mo.